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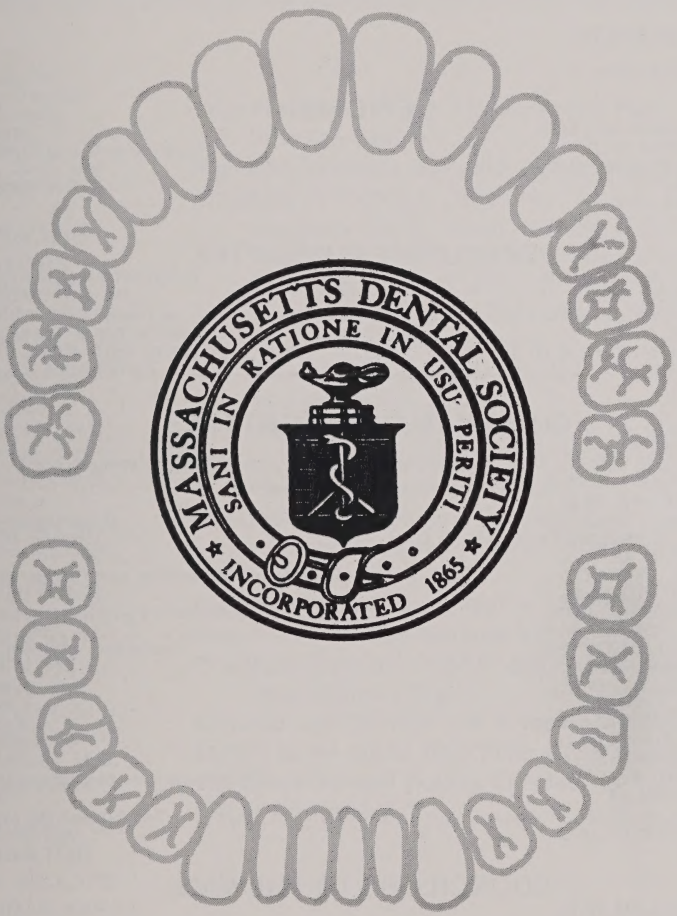

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Your President's Page

Medicine: Our Past And Our Future

At the turn of the past century, the five most common illnesses of man, to which he succumbed, were: (1) pneumonia; (2) tuberculosis; (3) typhoid and related infectious diseases of the gastro-intestinal tract; (4) diseases of the heart and (5) cerebro-vascular diseases. In the nineteen-seventies we find the five most common causes of death to be: (1) disorders of the heart; (2) followed with cancer of all forms; (3) cerebro-vascular diseases; (4) accidents; (5) influenza and associated diseases of the pulmonary system. In this period of time, man's average life expectancy at birth has increased from approximately 47 years in 1900 to 73.5 in the 70's. The reasons for this dramatic increase in life expectancy and respective changes in the major causes of death are both multiple and complex. Medicine though an art, has continuously allied itself with scientific skills and has conquered the infectious diseases and developed immunization procedures, with declining infant mortality and strengthened its diagnostic acumen in the fertile areas of preventive medicine. The Industrial Revolution also played a significant role. Included among the responsible factors were the improvements in environmental sanitation, in particular, water purification and sewage disposal. Improvements in the standard of living, housing, nutrition, communication and scientific breakthroughs, in the discovery, development and mass production of effective antibiotics and chemotherapeutic agents; all have ameliorated man's longevity. The decline of death rate in our early years, has placed man at the summit and threshold of death from the chronic degenerative diseases of aging as cardiovascular diseases and cancer.

I am not proposing, life eternal; for as Rene J. Dubois has written in his book, *Mirage of Health,* complete and lasting freedom from disease is but a dream . . . life is an adventure where nothing is static." While man lives longer, he succumbs to illnesses which are ever increasing and less encountered at the turn of the twentieth century. Among these are disorders of the respiratory system, in part brought about by his own complex industrial and occupational hazards and pollution. We note the ever mounting disorders of the gastro-intestinal system, from peptic ulcers to ulcerative colitis. The enormous increase of mental illness, both acute and chronic almost overshadowing all other disorders over the past 75 years. The deplorable increase of death toll from auto accidents, acts of violence, murder and suicide which are ever threatening our civilization like the brutal edge of a sword, severing the lives of many. Today, accidents comprise the fourth major cause of death.

In this complex world, we have bitterly learned that while we gain; we also can lose. The physicians of this century and our populace should not entirely focus their attention on the mere length of life. We should press our goals on the *quality* of life, rather than its duration. I am not advocating that we abandon the study

and research into the causes of arteriosclerosis, hypertension and cancer, which when conquered, will augment our life-span to the biological limit. What I am espousing is that equal concern be applied in bettering man's lot, while he is living in his productive years. Mental illness, rheumatoid arthritis, psoriasis and debilitating skin disorders, complications of diabetes, alcoholism, drug abuse and accidents are sapping and crippling the most productive and flowering years of our life. The sum total of the disorders, I have herein mentioned, numbers well over fifty million. There are countless millions, in addition, in our country alone, whose living standards are far below acceptable norms. It is this group, with monetary deprivation, where lack of skills, lack of schooling, lack of adequate housing and nutrition fosters and augments maternal death, infant mortality, the ever increasing rise of tuberculosis, morbidity and early demise. There is neither longevity of life nor quality of medicine for this unfortunate segment of our population. It is axiomatic, that the *economically deprived,* are also *medically deprived.* These two entities are one and inseparable. It demands the collective effort of medicine and man to bring about the mandatory changes to better the lives of those who are less fortunate than we.

It must be the concern of over 500,000 physicians and allied medical personnel, dentists, nurses, public health officers, psychologists and social workers. It must be the concern of each and every citizen and every state and federal legislator. This civilization of ours needs to become cognizant and sensitive and involved to the wants of others. We must *all* shoulder the blame for our apathy. As a nation of people, individually and collectively, we have become myopic and we have too long procrastinated for the tomorrows, what we must begin to do today. We can ill afford to look to our past heritage of performance as in: art, music, poetry, literature, communication, building of edifices, shortening the span of distance with ships, cars, planes and spaceships, scientific toiling of our soil, to feed so many and medical advances in prolonging the life-span of man.

It is time that we shape into form the fundamental priorities that man faces today; these priorities I have already outlined. As physicians, let us take leadership and become more involved in the public stream; join in the arena of other leaders in our communities and state and federal levels. It is not enough that we attend the ill in our offices and in the hospitals. Mankind through the centuries have looked upon us as sensitive and concerned segment of the world population and look to us, justly so, to actively participate in political and medical legislations and assume leadership in improving the quality of life and elimination of social ills which are ever present. Now, more than ever, the physician of today faces challenges, which will either carry him in the forefront of our present culture, or he will falter, relegating to others, what he was gifted to do from the very beginning.

Setrag A. Zacarian, M.D.

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Highlights of Recent Hampden District Meeting

The third District Meeting was held on Tuesday, February 5, 1974 at the Yankee Pedlar, Opera House in Holyoke, Massachusetts.

There were 130 reservations with 122 attending; twenty seven reserved and did not attend, 10 came without reservations.

The meeting was convened at 6:25 P. M. by Dr. Setrag Zacarian when a quorum of 50 members was present.

After motion duly made and seconded it was voted to waive the reading of the minutes of the November 30, 1973 meeting.

Dr. Zacarian called upon the secretary to capsulize the Proposed Rules and Regulation for Comprehensive Cancer Management in Hospitals that was prepared by the Massachusetts Department of Public Health. At the most recent District Leadership Conference a resolution against the proposed rules and regulations had been written. It was read to the membership for informational purposes. A public hearing will be held 7 P. M. on February 25, 1974 at the Springfield Municipal Hospital.

Dr. John Ayres, Chairman of the PSRO Committee for MMS gave an update report of PSRO.

Dr. William Mosig asked to speak to the members. He brought to their attention that direct billing for physicians services in hospitals was still being billed by the hospitals. This had been a subject of intense discussion a few years ago and he asked that HDMS again look into this matter and refer it to the Attorney General.

ANNOUNCEMENTS

HDMS Golf Day will be held July 17, 1974 at Twin Hills Country Club. Further details will be sent later.

The Council Meeting of the MMS will be held on Feb. 13, 1974. Suggestions were made to use car pools or buses to conserve the fuel crisis. The meeting will be held at 57 Howard Johnsons instead of the Statler.

The meeting was adjourned for a social hour.

After dinner Dr. Zacarian introduced the speaker, Dr. Richard E. Palmer, Secretary of the Board of Trustees of the A. M. A. Dr. Palmer's subject was broad and he illustrated the problems facing the AMA and indicated some of the solutions. Again it is a time for action and not reaction and grass root ideas are sought.

Respectfully submitted,
Walton E. Stevens, M. D.—Secretary
Hampden District Medical Society

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Introductory Article: DENTISTRY

The theme of this month's issue is Dentistry. The second major division within the Health Care Delivery System. While compiling the manuscripts for the "Getting It All Together" issue, it became abundantly clear that the subject of dentistry could of itself provide material for a single issue. Perhaps many physicians have kept up on the tremendous strides that have been made in dentistry, since its postwar renascence. I have not. The closest I have gotten to the changes and new concepts was as I sat in a dental chair and discussed the day's events with my dentist. I had not been exposed to dental progress in the literature or elsewhere. I have read and reread the manuscripts not only for editorial comment but for content. Each in its own way has much to tell the reader and physician. Our dental colleagues have not been just drilling and filling; they have specialized and they are practicing preventative medicine and dentistry. Good health, good dental health and good medical health are synonymous. I commend your attention to the following articles—to your perusal both as instructive and perhaps dentally helpful.

W. E. Stevens, M. D.—Editor in Chief

Dentistry 1974

Had Washington Irving cast Rip Van Winkle as a physician and sequestered him for the last twenty years rather than during the early part of the nineteenth century, the revised tale would be even more bizarre than the original. Although unplanned retirement would not be illogical, Doctor Winkle, at the least, would want to give serious thought to a short postgraduate course, if only to complete his own medicare forms. If he elected to plunge back into medicine, Rip doubtless would be hesitant to utilize diagnostic procedures employing isotopes, the welter of new chemotherapeutic agents including corticosteroids, sophisticated surgical advances and would wonder about the complexity of therapeutic modalities for cancer. Were he a general practitioner, Dr. R. V. W. would immediately take cognizance of the reduction in the incidence of communicable infectious diseases and the increase in cardiovascular, chronic debilitating and geriatric problems. Very likely obstetrics, orthopedics and even conditions requiring minor surgery would no longer be within his purview. Paradoxically, however, the markedly increased demands for his services and energies by patients, the hospital and continuing education would be immediately apparent. Doctor Rip Van Winkle might have difficulty in adjusting to the ever accelerating rate of scientific, clinical, organizational and socioeconomic changes.

The revised Washington Irving classic has an equally poignant counterpart in dentistry. During the period which has elapsed since the second world war, progress in the science and art of dentistry has dramatically altered dental health expectations for both child and adult. The typical dental therapeutic sequence during the first half of the twentieth century could well have been labeled P^6: "pain-patch-pain-pull-pain-prosthetics." While skillful restorative dentistry, pain control, exodontia and prosthetics continue to be as useful as ever, in 1974 the major thrust is centered on the prevention of oral disease and the preservation of a functioning, natural dentition free from pain and infection. Emphasizing adequate oral health education and available clinical knowledge, the dental profession is convinced that most individuals need not be distrubed by the onset of severe dental pain, ineffec-

tive or palliative dental procedures, unpleasant experiences in the dental office and the eventual loss of the natural dentition and associated structures with resultant unsatisfactory function and appearance.

Research on oral disease, nurtured by the ever increasing demand for comprehensive dental care by the public, continues to be the foundation upon which contemporary concepts of dental health are being built. The fifty one dental schools in the United States, all University affiliated, foster intensive research programs. In addition, separate graduate research centers, teaching hospitals and federal institutions add their impetus, spawning a literature so vast that no serious student could possibly digest. The recently published symposium ([1]) commemorating the twenty-fifth anniversary of the National Institute of Dental Research, an integral component of the National Institutes of Health, exemplifies the intense inquiry into the etiology, pathogenesis, epidemiology and therapy of many aspects of oral disease. While studies concerning dental caries and periodontal disease, the two major causes of tooth loss, were reported in depth, investigations into diseases of the oro-facial soft tissues, anomalies of craniofacial growth and development, pain control, as well as transplantation-implantation were also presented.

Fundamental research has demonstrated conclusively that dental caries is a complex infection involving the interaction of carbohydrate containing foodstuffs, a susceptible tooth surface and plaque-forming micro-organisms, particularly streptococcus mutans ([2]). This knowledge has been applied to achieve clinically effective, preventive measures. Nutritional conseling has become available, especially for highly susceptible juveniles. Topical and systemically administered fluorides have proven to elevate tooth surface resistance to decay. A more recent approach of preventive merit is the use of such tooth surface adhesives as bisphenol A-glycidl methacrylate ([3]). Although the microbial plaque is being assaulted by ever increasingly dedicated welders of toothbrushes, dental floss, and water jet devices, a broad public health approach undoubtedly will require the development of rational antibacterial agents and vaccines.

While dental caries and its sequellae are responsible for the loss of most teeth prior to the age of 35, the progressive destruction of the supporting dental structures, commonly known as periodontal disease (pyorrhea, chronic periodontitis), is the major cause of tooth mortality thereafter. Despite the fact that periodontal disease is usually associated with adulthood, it often originates in the juvenile population as a superficial chronic gingivitis progressing inexorably into the deeper attachment apparatus (cemental root surface, periodontal ligament and alveolar bone). Epidemiologic studies indicate that the condition, although largely asymptomatic, is universal, with manifestations recognizable in 75% of adults in the United States ([4]). Consideration of etiology is focused primarily on the intimate oral milieu of the gingival sulcus where the influence of the dental plaque, oral microbiota, materia alba, dental calculus and other irritants can initiate pathologic deepening into readily detectable, infected periodontal pockets, resorption of alveolar bone and lossening of the teeth. The rate of progress of the destructive lesion is modified by functional and systemic considerations. Such metabolic problems as diabetes, however, per se do not initiate damage to the periodontium.

Ernest A. Byron, Jr.

SPRINGFIELD

Most chronic periodontal disease is preventable. The dental clinician can motivate adequate oral hygiene, thereby establishing an effective plaque control program. This hygienic cooperation, when coupled in the dental office with periodic removal of local irritants including dental calculus, carious lesions, ill-fitting restorations and sites of food impaction, together with the establishment of a physiologic dental occlusion, will insure the health of the dental attachment apparatus. Furthermore, for those with incipient or even moderately advanced chronic periodontitis, effective therapeutic measures, including surgical techniques for the eradication of periodontal pockets, the reestablishment of a physiologic gingival contour and occlusion, are invariably successful. Research in the periodontal field currently is directed toward the complexities of the dental plaque, immunologic defense mechanisms and the role of functional stresses of the dental occlusion.

While prevention of debilitating oral disease is the dominant theme of dental practice in 1974, it is evident that the dentist cannot, in the foreseeable future, discard the drill, amalgam plugger, scaler, root canal reamer, impression tray and unfortunately even the extraction forceps. The December 1972 report and Recommendations from the Advisory Committee on Dental Health to the Secretary, Department of Health, Education and Welfare are pertinent ([5]):

"Dimensions of Dental Health Problem"

—Dental disease is all but universal;
—Fewer than half the people in this country have dental exams or treatment in a given year; far fewer than that receive dental care on a regular basis;
—By age two, approximately 50 percent of America's children have experienced tooth decay. On entering school, the average child has three decayed teeth and by age 15, the average child has 11 decayed, missing or filled;
—approximately 50 percent of the children in America have gingivitis, which can lead to progressive periodontal disease, a major cause of tooth loss in adults;
—Nearly 50 percent of all children under age 15 have never been to a dentist. This percentage is substantially higher for children in rural areas;
—Almost 70 percent of the children in poor families have never been to a dentist;
—Over 50 percent of all Americans over age 65 have lost all of their natural teeth;
—Of the total adult population of approximately 110 million, more than 20 million have lost all their natural teeth; of the 90 million with teeth, 25 percent have destructive periodontal disease and over 50 percent have some stage of gingivitis;
—Cleft palate, with or without cleft lip, occurs about once in every 700 births or about 6,500 such births annually;
—Oral cancer is discovered in 14,000 new patients each year and accounts for over 7,000 deaths yearly. Of those who have had treatment, approximately 22 percent are in need of maxillofacial prosthesis;
—For every 100 Selective Service recruits, the Armed Forces needs to perform or supply 500 fillings, 80 extractions, 25 bridges and 20 dentures.

Because of the magnitude of the dental health problem, the adequacy and the costs of dental care have been subjected to intense inquiry. The efficiency of the typical solo practitioner office has been equated with that of the cottage industry of Rip Van Winkle—s time and found unequal to the challenge of meeting current dental health requirements. The backlog of unfulfilled needs, together with increasing demand for dental services by an informed public, has resulted in significant changes in the pattern of dental practice.

The most important step in improved productivity is the augmented use of auxiliary personnel ([6]), both in numbers and responsibility, with some of the concepts derived from the hospital operating room. The broadening scope of duties of auxiliaries is leading to legislative revision of dental practice acts throughout the United States. With the development of a team approach, office and equipment design have necessarily become more flexible, complex and expensive. The problems associated with supervision of multiple personnel and costly plants have in turn fostered formation of group practices in ever increasing numbers.

With the growing complexity of dental care, the emergence of specialization within the dental profession has accelerated. The latest inventory ([7]) indicates that 8.5% of the 123,575 U. S. dentists are limited to one of the eight fields of dental specialization recognized by the Council on Dental Education of the American Dental Association. Each of these specialties now requires at least two years of graduate education for limitation of practice and eligibility for American Board certification. The recognized fields of dental specialization are orthodontics, oral surgery, periodontics, prosthetics, endodontics (root canal), oral pathology and dental public health.

The dentist, be he general practitioner or specialist, has been made much more aware of the socio-economic and political forces reshaping health care in our nation. Together with his medical colleagues, those who perform dentistry and surgery in a hospital have learned the obligations and restrictions imposed by utilization committees, the Joint Commission on Accreditation and Blue Cross-Blue Shield. PSRO's, HMO's, health foundations and political action committees have become as much a part of dental as medical lexicon. The dentist knows that he too must deal with increasing efforts at regulation by government, trade unions, insurance companies and dental service corporations.

It is certain that when federal health insurance descends, no matter what form it ultimately assumes, dental care will be woven into the overall tapestry of regulated health care. Communication, understanding and cooperative action between the medical and dental professions are essential lest an imperfect tapestry result from a faulty design.

Or, as Washington Irving wrote

> "Even to this day they never hear a thunderstorm of a summer afternoon about the Kaatskill, but they say Hendrick Hudson and his crew are at their game of ninepins; and it is a common wish of all hen-pecked husbands in their neighborhood, when life hangs heavy on their hands, that they might have a quieting draught out of Rip Van Winkle's flagon."

Leon A. Weiss, D. D. S.

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* * *

An Overall Look at Organized Dentistry

The American Dental Society (ADA) represents almost 119,000 dentists throughout the United States, Puerto Rico, Guam, and in the Armed Services and United States Public Health Service. It is comprised of general dentists, specialists (although there are societies for the various specialties), educators, researchers, and the students in dental schools. The dentist pays one fee and is a member of the local, state, and national societies. He must join all or none, and he receives benefits from all three levels of the society. To be a member of any of the specialists' societies, he must be a member in good standing of the A. D. A.

To govern this group, the A. D. A. is divided into state societies and within the states are varying numbers of local societies; this number depends upon geography and numbers of dentists within the State. The local societies elect delegates to sit in the House of Delegates of the State and the A. D. A. The number of delegates for the area is proportional to the number of dentists in the area. The same person can be elected to be both State and A. D. A. delegate, for the state house of delegates meetings are usually only two-day semi-annual meetings and the A. D. A. house of delegates is a five-day annual meeting and are not concurrent. The house of delegates on both national and state levels set general policy. During the interim the societies on both levels are run by a Board of Trustees. The State Trustees usually meet monthly for a day, while the A. D. A. Board of Trustees meet every other month for three or four days. The State Trustees are elected by the local societies and the numbers vary with the number of dentists in geographical area. The A. D. A., on the other hand, has 14 Trustee Districts. (The First District is comprised of the six New England states.) The Trustees from these Districts are elected by the delegates to the A. D. A. House of Delegates from within the District. The President of the A. D. A. is also elected by the Delegates to the A. D. A. House of Delegates.

To run the local, state, and A. D. A. offices on a day to day basis, each has its own executive staff which is hired by the Board of Trustees.

In order to further divide the work, the local, state, and national societies have 17 Councils. In these Councils, the chairman of the local Council is usually on the State Council and the chairman of the State Council is usually on the A. D. A. Council. These Councils cover such areas as: Hospital Dental Service Insurance, Legislation, Dental Therapeutics, Dental Materials, Dental Education and Relief. The Councils bring in reports, recommendations, and resolutions to both trustees and House of Delegates. The Councils also may hire their own staff, depending upon their budget and work.

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As far as legislation is concerned, the Legislative Council may or may not hire lobbyists in the various states. The A. D. A. has a Washington, D. C. office and its own budget. There is also a completely separate organization which dentists are urged to join on a state and national level called the Political Action Committee. This Political Action Committee donates money to the political campaigns of those politicians who have in the past, or indicate that in the future they will listen to the leaders of organized dentistry before they cast their vote on legislation affecting dentistry.

The dental society backs financially and with personnel National Children's Dental Health Week and in the Commonwealth of Massachusetts, Dental Health Month. During this time in the month of February a concerted effort is put forth to dramatize the importance of dental health. Newspaper, radio, and television are all approached to help demonstrate the advantages of regular dental care.

Until recently, Massachusetts was near the bottom of the list of states in terms of percentage of the population receiving the benefits of fluoridation. This reluctance to accept the benefits of the most researched of all public health measures in the history of medicine has cost the citizens of Massachusetts dearly in private and public money and in pain and suffering. Due to recent action by the legislature, monies have been allocated to start the planning and implementation of the fluoridation for Metropolitan Boston. When the water of this urban area has its fluoride content adjusted to the optimum level, the amount of taxpayers' money spent to alleviate the dental needs of those people who receive State Aid will diminish perceptibly. Incidentally, about twenty-five million dollars was spent this past year by the State for dental treatment. At this point, I would like to thank all the physicians who individually and collectively have lent their names and time to help the Massachusetts Dental Society in this public health endeavor.

In the future it is evident that the Medical and Dental Societies on all levels of their organization must work together to promote the health and welfare of the general populace and to keep this promotion of health where it belongs—In The Hands Of The Private Practitioner.

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The New Role of the Physician in Children's Dental Health

After World War II, a review of Selective Service records revealed that dental disease was prevalent in epidemic proportions and was due, for the most part, to a lack of dental health education and interest in the early care of the childhood dentition. In 1945 only three graduate programs were available to those interested in advanced study in pediatric dentistry and only five dental schools offered clinical training in this field. The realization of the importance of prevention and dental treatment in early childhood has led to a tremendous growth in the number of graduate programs in the field of Pedodontics or Pediatric Dentistry.

It is often unrecognized by the medical profession and the general public that the background, the experience, and the scope of endeavor between the general practitioner of dentistry and the Pedodontist is quite diverse. A Pedodontist is truly a specialist in the dental treatment of children and prepares himself for this endeavor through a recognized discipline of graduate training, internship and residency. Only recently, the dental profession has started to break through the misconceptions and prejudices held by physicians, who have long considered the dentist as one who merely employs mechanical techniques, and has nothing to do with the physical condition of the patient beyond those conditions related to the teeth and the immediate adjacent structures. It is well accepted among the medical profession that treatment of any disease cannot be accomplished without consideration of the whole patient. It is not surprising, then, that dental treatment is no exception. The modern pedodontist with his experience and training has a comprehensive knowledge of pediatric problems, particularly those overlapping dentistry. As knowledge expands, it becomes imperative that there be more cooperation and a greater flow of knowledge between pediatricians and pedodontists so that our patients can benefit from sound comprehensive health care.

To begin this exchange of knowledge, it is appropriate to discuss the "new look" in pediatric dentistry, namely prevention. When we were children, dentists mainly followed the drill 'em and fill 'em practice philosophy in the treatment of man's most prevalent disease, dental caries. And frequently, relief of pain was by extraction of a badly decayed and excruciatingly painful tooth.

Today, like the physicians, dentists (general practitioner and pedodontists alike) spend much of their energies preventing disease. To do this we need a basic knowledge of the mechanism of the disease process. It must be understood from the outset that dental caries is a specific infection. The bacteria primarily responsible for this infection are certain forms of streptococci. These streptococci adhere to the tooth surface and possess certain mechanisms to protect themselves from a

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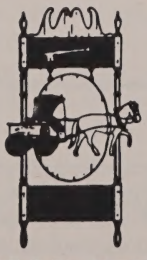

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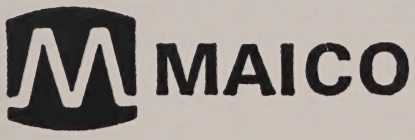
rather hostile oral environment. These colonies called dental plaque, grow on the tooth surfaces and produce acids which break down the enamel structure, hence, we have dental caries; not a hole in a tooth but an *infection.*

Research has shown us that the mechanism of plaque formation cannot take place without a plentiful supply of sucrose in the diet. The streptococci metabolize the sucrose to produce dextran, a strictly polysaccharine substance, in order to adhere to smooth surfaces of teeth. Once this process takes place and plaque is well established, other types of sugar can be utilized by the bacteria in acid production.

It is obvious, then, that prevention involves nutritional evaluation and guidance. It is far easier to prevent the formation of plaque by reducing sucrose intake than it is for children to try to remove it by mechanical means with floss and toothbrush. Good dietary regimes should be instituted in early childhood, long before the family seeks dental care, and, therefore, the responsibility falls mainly on the family pediatrician. For at least the first two years of a child's life, it is the physician who takes over the responsibility of the dietary aspects of preventive dentistry.

A second area in which we must be knowledgable is the mechanism of fluoride uptake and its relation to dental disease. We know that fluorides in the water supply results in a significantly reduced decay rate. Only recently, investigators have studied the mechanism of fluoride utilization in the body and have begun to ask whether reduced decay rates are due to a surface phenomenon on the tooth enamel or some systemic mechanism in which the fluoride reaches the enamel through the dental pulp. Other investigations under way are studies involving the fluoride ion at the placental barrier.



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At the present time it is believed that fluoride does not cross the placenta and, therefore, is of little significance prenatally. Furthermore, it is believed that fluoride has some effect during the calcification portion of tooth development, but the most recent evidence shows that the major effect of fluorides on post eruptive enamel is a surface phenomenon. Chemically and microscopically one can show a layer 30-60 micra thick on the surface enamel that is affected by continual fluoride contact. This contact can be in the form of fluoride lozenges, mouthwashes and toothpastes. There seems to be little or no evidence that this situation exists when only systemic fluorides are used. With this in mind, one has to re-evaluate the method in which we provide supplimental fluorides to our patients. If a child is given fluoride tablets (with or without vitamins) and swallows these without dissolving them in the mouth, it is questionable whether we are providing maximum fluoride protection. If, however, we use fluoride in a liquid form, then we are insuring this surface effect on the posteruptive enamel of the teeth.

These are the kind of exchanges that are needed between the medical and dental professions. Remember, the first health professional to look into a baby's mouth is the family pediatrician or physician. Therefore, he is the first to have the opportunity to spot dental and soft tissue anomalies, and pathology. It is the physician whom the dentist must depend on to prescribe supplemental fluorides from birth when they are needed; who will first see natal teeth, other eruption problems, early caries and damage due to trauma.

Indeed, it is the physician who must instruct the family that the child's first visit to the dentist should be at 2-1/2—3 years of age, and to be sure such a visit takes place. On the other hand, the physician can expect us to refer patients with oral manifestations of systemic illness which are not uncommon in children.

Medicine has made great and rapid advances in our lifetime. So, too, has dentistry. Both have so well conquered existing disease that they have been able to turn their attention to the prevention of disease. The time has come when no tooth need be lost to dental caries, when no child need have "crooked" teeth, when gum diseases (the major dental plague of adults) can be avoided.

Such prevention would parallel the prevention of polio by the Sabin vaccine. Preventive dentistry, however, also needs widespread practice among the public. The forces of dentistry can't do it alone. They need the help of the forces of medicine. Together, we can stave off mouth diseases and keep America's children smiling happily throughout life.

David L. Webber D. D. S.
Neil B. Epstein D. M. D.

* * *

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How the General Practitioner of Dentistry Fits into General Health Care System

Dental education to the public has greatly improved over the years as has the image of the general practitioner in dentistry.

That is not to say that both aspects have reached the ultimate in these respects, but it does mean that many dentists do see most of their patients at least twice a year for their dental check ups to maintain good oral health.

It also means, that in some cases, we, as dentists, see our patients more often than does the physician, who might see the same patient only when he has an illness or a complaint about his health and does not believe in taking medications except for these reasons.

And there are some patients, that for religious reasons, do not believe in taking medications, but do take care of their oral problems routinely for cosmetic and functional reasons.

With these routine visits biannually, we have a chance to examine the whole oral cavity, as well as the teeth, and discuss briefly other health problems that they might have.

If I find any health problems either oral or general that are beyond my scope, I do not hesitate to recommend that the patient see a specialist in the medical or dental field or a physician in general practice because I feel that this is my responsibility.

Over the past fifteen years, I have diagnosed several cases of oral carcinomas in the early stages and a couple of advanced cases that had procrastinated about seeing a dentist or a physician until it was too late.

I had two young ladies that I embarrassed by asking if they were pregnant when they asked about their "bleeding gums" and hypertrophied tissue between their teeth. They later called and confirmed my suspicions.

Of course, Koplik Spots often times are found before other symptoms of measles appear and mumps are often confused for a dental problem.

The days of extracting all the teeth of a person with arthritis are now gone because we try to treat the peridontal diseases before they get to the point of being a focal spot of infection.

We find that many physicians refer their patients to their dentists to rule out dental cause before sending them on to more elaborate and costly medical bills of their specialists or hospitals.

Because of this mutual understanding and upgrading of the dental image, I think that we as dentists have taken a definite role in the "dental health care system" and have been recognized as being the specialists that we are of the oral cavity.

Dwight R. Magovern, D. M. D.

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Hampden News Items and Capsules:

The Executive Committee of the HDMS's meeting scheduled for Tuesday, February 19th was not called to order for lack of a quorum. One item will be directed to Dr. John Turner's Mediation Committee. The remainder will be placed on the agenda for the next scheduled meeting the 19th of March.

The Annual Meeting of the Hampden District Medical Society will be held on April 30, 1974 at the Stage Coach Barn, Storrowtown, West Springfield.

The HDMS, through our gracious Executive Secretary, will provide the theme and program for the Greater Springfield Chamber of Commerce on April 10, 1974. The overall theme is "Heritage and Horizons" in keeping with Springfield's Bicentennial Celebration. The guest of honor will be the President-Elect of the American Medical Association, Dr. Malcolm Todd. The Quadrangle of the Armory, through the courtesy of Springfield Technical Community College, will be the meeting's location site. Dr. Setrag Zacarian will chair the section on health entitled "Horizons for Health Services" in which Dr. Todd will speak on "National Health Insurance."

Notice: The Massachusetts Medical Society Council Meeting date has been changed to June 5th, 1974, in Boston.

The Annual Meeting of the Massachusetts Medical Society will be as scheduled May 28, 29 and 30, 1974, in Boston.

Kollegal S. Murthy, M. D. has been elected to Fellowship in the American College of Physicians.

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THE SPRINGFIELD ACADEMY OF MEDICINE

NEXT MEETING:
Tuesday, April 9, 1974
Speaker:
RICHARD P. SPENCER, M.D.
Professor Nuclear Medicine
Yale University School of Medicine
Topic:
"Studies of the Spleen"

CLINIC: No Session

Letter To Editor

Walton Stevens, M. D.
Editor
Hampden Hippocrat
Dear Editor:

I rise to a point of personal privilege and take exception to your Editor's Note attached to my article, "A Matter of Rules," and wonder why the editor couldn't call an associate editor over an apparent contradiction.

The Council of the MMS is still operating under Robert's Rules of Order and this will not be changed until and unless the proposed bylaws are adopted. There is a special meeting of the Council on March 13 to consider the proposed bylaws. If the Council adopts the proposed bylaws and the annual meeting on May 29 concurs, then and only then will we be operating under Sturgis' Parliamentary Procedure, 2nd Ed., 1965. You realize, of course, that the proposed bylaws can still be amended on this point.

Trusting that this explanation clarifies your understanding of the rules we are now following, I would also like to add that Alice Sturgis' name was misspelled, as well as my own.

Very truly yours,
James D. Allan, M. D.
Associate Editor

* * *

Series Article:

A Matter of Rules

Part Two: Motions

A motion is a proposal that the assembly take certain action, or that it express itself as holding certain views. In effect, a "resolution" is merely a *main* motion which is of such importance or length that it is presented in written form and usually contains a preamble beginning with several "Whereases." It is important to remember that the preamble of a resolution is *not* part of the motion; it *cannot* be amended and it does not become part of the minutes. The preamble merely gives an explanation of the need for the resolution. Therefore, only the resolution itself is the *main* motion.

Now that I have introduced the term *main* motion, it would be best to explain that there are Privileged, Subsidiary, Incidental, Main, and Unclassified motions. The types of motions are given rank or precedence over others. For example, *Privileged* motions, such as: (a) Fix time to adjourn, (b) Adjourn, (c) Take a Recess, (d) Rise to a Question of Privilege (rights of the individual or the assembly such as, "too hot," "can't hear," etc.), and (e) Call for Orders of the Day (that is, request that the agenda be adhered to), have precedence (rank) over *Subsidiary* motions, such as: (a) Lay on the Table, (b) Call for the Previous Question, (c) Limit or Extend Debate, (d) Postpone to Definite Time, (e) Refer to Committee (or recommit), (f) Amend, and (g) Postpone Indefinitely. Both *Privileged* and *Subsidiary* motions take precedence over *Main* motions. *Incidental* motions have no rank, but take precedence over the *Main* motions they affect. Some examples are: (a) Appeal a Point of Order, (b) Object to Consideration, (c) Suspend the Rules, (d) Withdraw a Motion, (e) Division of a Question, (f) Consideration by Paragraph, (g) Point of Order, and (h) Rise to a Parliamentary Inquiry.

The list seems long and indigestible, but these individual motions and the object for using them can be found in Robert's Cushing's, or Sturgis' Rules of Order at any bookstore. However, it would be better to get back to my basic format.

In order to introduce a motion, one must first obtain the floor by rising and addressing the presiding officer by stating the purpose of taking the floor. If one is entitled to be heard at that point in time, the presiding officer will assign the floor; if not, the presiding officer will merely state that "you are out of order." The floor is given to the first one who rises and whose voice is heard and whose request is pertinent to the question.

Let us assume that a motion duly seconded is before the assembly and you wish to rise in opposition or support. Do so; this becomes proper debate. Remember the following points: (a) Maintain decorum, (b) Speech is limited to ten minutes at a time (unless a prior two-thirds motion has limited debate). (c) You cannot speak a second time untill all others have had a right to speak first, and (d) You may speak before your second time is due if it is clearly to explain a statement or to change your position on the motion.

Perhaps you feel the motion is not in its best form for adoption and you wish to amend it. The object then is to change or modify the motion with an amendment, which must be germane to the subject matter of the motion. It is best to quickly write down your amendment so that the secretary can receive it correctly. This is not ordered, but it is a help when debate becomes hectic. You then rise, obtain the floor, and move your amendment. Remember, there must be a second and amendments can also be amended. In fact, a

main motion can have any number of amendments attached before any vote is taken but, as a matter of practicality, the Society's presiding officer usually will restrict the assembly to only three to five amendments. Once an amendment has been made and seconded, it then becomes the question before the assembly. That is, the main motion is temporarily put aside and debate takes place on the amendment. Should another amendment be made and seconded, it then becomes the question for debate, and the main question and the first amendment are temporarily put aside. Thus, the assembly proceeds until there are no further amendments. The problem which frequently arises is the confusion among the members of the assembly as to the exact question before it. Therefore, the presiding officer or the secretary should frequently remind the assembly as to the wording of the question. This is important because only the question or amendment may be debated, and not that which has been temporarily put aside. When debate on the last amendment is complete, then a vote is taken on the amendment only. If the vote is in the affirmative, it becomes part of the main motion (or the motion to which it refers). At this point debate is resumed on the preceding amendment (if there was one) and another vote is taken. In other words, the amendments are voted on in the reverse order of the way they were presented to the assembly. If they carry, they change or modify the motion to which they were attached. If they are defeated, they cannot be presented again, but debate and voting continues until all the questions are resolved. The main motion with or without amendments is now before the assembly and is again debatable. However, the presiding officer usually asks, "Are you ready for the question?" If he hears no objection, a vote is taken. If he hears an objection, debate resumes; but at this point the assembly usually senses its own will and either "moves the question" which is not debatable but requires a two-thirds vote, or "moves to commit" (refer to committee), which is debatable only insofar as the propriety of committing, but this only requires a majority vote. The latter two motions are Subsidiary motions.

In subsequent articles an attempt will be made to indicate the purpose of other types of motions and the functions of committees.

James D. Allan, M. D.

* * *

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if he keeps it, he's a miser;

if he spend's it, he's a playboy;

if he doesn't get it, he's a ne'er-do-well;

if he gets it without working, he's a parasite;

if he doesn't try to get it, he lacks ambition;

and if he accumulates it after a lifetime of hard work,

he's a fool who never got anything out of life.

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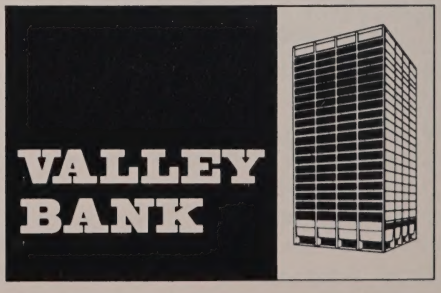

Food For Thought:

A. M. A. News Jan 21, 1974

New licensing law enacted

Michigan Gov. William Milliken has signed into law a new Medical Regulation and Licensing Act to replace a law instituted in 1899.

Members of the State Board of Registration and Medicine, in concert with the Michigan State Medical Society Council, are developing rules and regulations for implementation. Basically, the bill would provide for more appropriate forms of discipline for physicians.

Specifically, it would:

- Create a Medical Practice Board containing one public member to replace the current Board of Registration.
- Allow the board to deny, issue, limit, suspend, and revoke licenses to practice medicine and otherwise discipline physicians for unprofessional or dishonest conduct. (The only disciplinary action available to the current board is suspension or revocation of a license.)
- Outline requirements an applicant must meet to receive a license and allow the board to determine the nature of the licensing examination.
- Define unprofessional or dishonest conduct, including illegal use of drugs, immoral conduct, obtaining money by fraudulent misrepresentation, among others. The board also could revoke a license for conviction of a felony or misdemeanor.
- Allow the board to take action against a physician for inability to practice medicine because of illness, use of drugs or alcohol, or his mental condition. It also could reinstate a license or grant a limited license.

Editor's Note: Your opinion and ideas are solicited. Should the Massachusetts Medical Society look into a similar updating?

Notice:

Please note that the Symposium on Medical Ethics, originally scheduled for Wednesday, February 20th has been postponed.

It will now take place on Wednesday, April 24, 1974 from 1 through 5 p.m.

Symposium—Medical Ethical Problems in Pediatrics.

Participants—Medical Ethics Committee, Kennedy Foundation, Harvard Medical School.

Location—Springfield Hospital Medical Center, Auditorium—3rd floor.

. . . enter the date of April 24th on your calendar

Morris Medalie, M.D.,
Pediatrician in Chief

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5 Massachusetts PSRO Areas Designated

The U.S. Department of Health Education and Welfare acting under the provisions of Public Law 92-603 has divided Massachusetts into five Professional Standards Review Organizations areas. The five areas are comprised of the following cities and towns:

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North Adams
Adams
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Colrain
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Bernardston
Northfield
Warwick
Orange
Savoy
Charlemont
Hawley
Buckland
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Greenfield
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Erving
Hancock
New Ashford
Cheshire
Windsor
Plainfield
Ashfield
Conway
Deerfield
Montaque
Wendell
New Salem
Lanesborough
Blandford
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Westfield
Southampton
Easthampton
Holyoke
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Ludlow
Belchertown
Ware
Palmer
Egremont
Mount Washington
Sheffield
New Marlborough
Sandisfield
Tolland
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Holland
Warren
Pittsfield
Richmond
Leverett
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Westhampton
Northampton
Hadley
Amherst
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One Man's Opinion . . .

PSRO: Bombshell of the Century!!!

" . . . the PSRO legislation will have greater impact on the practice of medicine than any other health legislation that has ever been enacted here or any place in the world."—H. E. Simmons, MD, MPH, Deputy Assistant Director, HEW.

It has been estimated that 80 per cent of all practicing physicians know very little or nothing at all about the PSRO law.

This estimate was probably true several months ago, but not today—not if we are to judge by the many, many voices that have been raised of late in opposition to this item of legislation.

The first inkling of PSRO to reach the medical practitioner was accompanied by the admonition: "It's the law of the land and we'll just have to learn to live with it." When the Association of American Physicians and Surgeons filed suit last spring challenging the constitutionality of the PSRO law, it was brushed off by many as a dissident act of a disgruntled ultra-conservative minority faction. This, we have since learned, was an erroneous assumption. Eight state medical societies, including Michigan, several big California county societies and the American Society of Anesthesiology also have taken an unequivocal stand against PSRO. Moreover, several recent polls indicate that a substantial majority of the nation's MD's are in favor of its repeal. Final proof of medicine's opposition to the "Bennett Amendment" is to be found in the action taken early last December in Anaheim, Calif. There, at the AMA's midyear meeting, the House of Delegates, against the advice of the AMA leadership, voted that "The best interests of the American People would be served by repeal of the present PSRO legislation."

It is generally agreed that the chances for repeal of the PSRO law are slim, and that the most we can hope for is the adoption of one or more ameliorating amendments. But regardless of the outcome the fact remains that more and more MD's are finding PSRO in its present form unacceptable. The questions yet to be answered are: why was our profession so slow in realizing the impact and forebodings of this law? Why wasn't more done about it before its enactment? Most of all, why were the grassrooters kept in the dark for so many months before and after its enactment?

For one thing PSRO was a "backdoor," last-minute type of legislation. It was slipped through the U. S. Congress on October 17, 1972 in the rush to adjournment the following day. Quoting the Wall Street Journal, "It was attached by Sen. Bennett (R. Utah) as a rider onto last fall's big and controversial Social Security bill and somehow rode through with almost no public attention. The House did not even hold hearings on the PSROs."

Another reason why we were so slow in grasping its significance is because the PSRO law is extremely complicated, even for Washington. To unravel the gobbledygook of its 17 pages of fine print would tax the wizardry and mental agility of the proverbial Philadelphia lawyer. Most of its detail, Washington admits, is yet to be worked out. The majority of congressmen to this day are still hazy about its content, let alone its significance. Its very title is forbidding: "Professional Standards Review Organization, an Amendment to the Social Security Act Section 249F, Public Law 92-603."

Highly significant is the disclosure by Sen. Bennett of the deplorable power struggle raging now inside HEW for control of PSRO administration and operation. Within HEW, according to the senator, ". . . PSRO has yet to assume substance—they are still playing the bureaucratic game of who will get to do what." Senator Bennett concludes: "Tomorrow, supposedly, will be better, according to HEW. That is probably true, because today couldn't be much worse." (Bul. Am. Col. Surgeon 12/73)

At the beginning the AMA refused to support the PSRO bill ". . . believing that it was too structured, too regulatory and needed more study." Subsequent objections raised by other segments of our profession included escalating bureaucratic intrusion, violation of physician-patient confidentiality, the high cost of administering the act and finally, the inevitable sacrifice (notwithstanding denial) of "quality" for "cost" in health care. Most disturbing is the premonition that the worst is yet to come. Dr. C. C. Edwards of HEW admits that the PSRO impact will not be felt until 1975. Locally, we have until January, 1976 to prove that we can administer the PSRO act to the satisfaction of HEW. Dissatisfaction on the part of HEW, which many believe is a foregone conclusion, will authorize that department to appoint its own agencies to do the administering.

Only those who have never read the PSRO act carefully can possibly remain indifferent to its implications. Senator Bennett's address before our Society on November 30, was more of a sales pitch than a clarification of the issues involved. Many physicians are lulled into apathy, believing as they do that PSRO monitoring will be carried out exclusively by their peers and that it will apply only to hospital medicare and medicaid patients. Quoting the AMA (PRISM, Oct., 1973): "Initially, the primary concern will be review of care provided in hospitals . . . . Eventually, PSRO's may monitor all services which are paid, wholly or in part, by Social Security." As to the question of "peer review" we must realize that this is guaranteed only until January, 1976, following which the interpretation of the term "professional" will be left entirely to the discretion of HEW.

Our parent organizations are now in the midst of endeavoring to bring about a modification of the more menacing features of the PSRO act. They need all the support we can offer, individually as well as collectively. Shall we poll or canvass our membership on the question of PSRO? Shall we, as a district Society, establish a PSRO committee of our own? These are pertinent questions to ponder. What requires no deliberation, however, is the need to keep our membership as well as the public fully informed of the health hazards inherent in the PSRO law.

May Millman, M. D.

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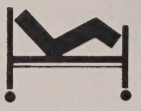

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Editorial: Ad Oblivion

In typical, predictable fashion the medical mastodon rolled on to the edge of oblivion. Unable to scent the change in the wind, unable to let go of the tail ahead and unable to stop and take a look at its position or destination. The various presentations had been shorn of any clout by the annoucement that the Commissioner of Public Health was appointing an additional group to look into revision of the subject matter for the evening's Public Hearing. It still was essential that those individuals representing institutions and groups, present their papers so that their thoughts can be conveyed to Boston for proper committee action, but how anticlimactic! What a disaster to the species!

The herd instinct maintained itself throughout the evening with the community leaders juggling for position. All condemning—their theme was "we approve in principle, but . . . " There were no counterproposals, there were no simple plans of modification, which would allow some usefulness to be extracted from the shambles of the *Final Draft*. Over the edge they tumbled, as blind as when Medicare was in the planning stage.

The tools, the knowhow and more important the ideas and guts to develop and deliver an approvable *System of Cancer Management*, sat in the Municipal Hospital Auditorium. But REACT not ACT was the continuing order of the night. That a new system can be developed; that the disease concept of the practice of medicine is viable, providing the prime physician remains in charge of his patient; that a new era of medical practice is upon us—suffered the same fate as the mastodon. But it seemed to bother only a few in the room.

Cancer management by oncologists and the patient's prime physician could be the bellwether for future disease-concept approaches to the practice of medicine in those disease entities which require super-expertise of personnel, super-sophistication of equipment and wherein the total, final cost of care falls beyond the limits of good medical health insurance. The geometric rate of acquired knowledge growth, the current energy crises, the need to conserve for ecologic and common sense reasons the strategic and essential supplies and personnel of our country should only further indicate that the universal physician of the thirties and

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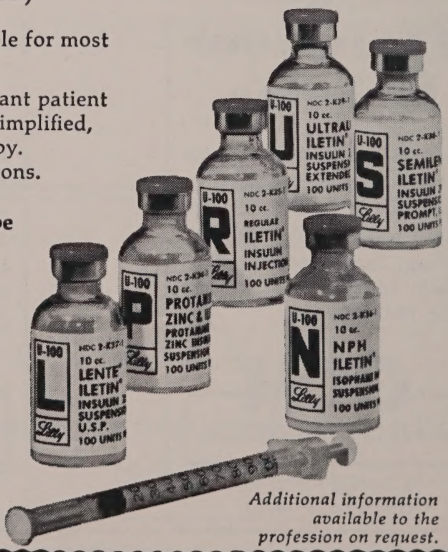

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forties, who has found it necessary to give way to the special physician of the fifties and sixties, who in turn is now being replaced by the super-special physician (really a limited-physician) of the seventies and eighties will have his day. The prime physician will be trained to diagnose a condition but care and management will be assumed by the superspecialist until the patient can again be managed by his L. M. D.

In my own field of radiation therapy, this type of patient-physician cross referral and limited practice has been going on in increasing increments over the past 15 years. The general practitioner is now content to leave renal dialysis to the nephrologist and the general surgeon is content to leave the heart transplants to the superspecialist. Thus, the concept is not new, nor revolutionary but represents an evolutionary medical trend. Why then the primordial fear of the disease-concept approach to cancer? Many of us in cancer management had and have agreed that the *Final Draft*, imperfect as it was, did provide a framework from which a workable, practical system could be developed. Governmental control through fiscal manipulation and through regulations exists. The laws are active and being pursued. It behooves the physician to assist in the guidance and direction of interpretations of the law. The old cliche of "if'n you can't beat them, join them!" still applies. Zero input—zero input.

There is ample reason to believe that the Department of Public Health did overstep its prerogatives and jurisdiction by creating *de novo* a cancer care and management system and promulgating it in the manner and fashion it did. In fact, it itself raised that question in the preamble to its Proposal. I am as annoyed as my fellow physician when one agency attempts to regulate the practice of medicine and surgery, over which it has no direct influence. But another issue is equally important, it is that the Department of Public Health *had to create de novo*, a plan for cancer management to fill a vacuum! Are there no physicians, can not organized medicine develop a plan for cancer management? The excuse that we all are too busy to create, too busy to stop and ponder our direction and too busy to see the new forces working on and through medicine is not valid. The February Editorial indicated that the Massachusetts Medical Society has set itself to the task of formulating a plan which "will insure the highest quality of care without restriction of patient or physicians rights . . . " This will be and have a broad interpretation. The specialty societies should create more narrow interpretations as they apply to each field. Where overlap exists, overlapping committees by two or more societies should fuse the management plans and spheres of interest. Jurisdictional problems related to PSRO reviews will require intra-specialty cooperation and what better mechanism than through organized (well organized!) medicine and its specialty groups?

Perhaps the defeat is only temporary and the Commissioner's new committee will be able to, with assistance from the Massachusetts Medical Society, produce a workable draft which will allow the patient the best of care close to home, at the least expense and by the best trained physician for the job. To be avoided and prevented will be powerploys by special interest groups; the patient-public shall not have its best interest dissected by a group of egomaniacs, either representing a hospital, a specialty or only themselves. I am sure as physicians we will have to deal with not only a state level cancer management plan but a national level plan as well, within the next five years.

When the future medical archeologists sift through the debris at the bottom of the cliff, perhaps they will be able to read the signs that not all went this way, but that a few stopped short of the edge. A few who were not blinded and who could let go, who now as a new species can be found grazing peacefully on the highlands. A few who are respected not only for their bulk (organization) but for their vision (cooperative foresight) and interest in other species (humaneness).

W. E. Stevens, M. D.

Letter to Editor

Dear Sir:

Being a newcomer to the community I was appalled by the injustice the Commonwealth's Department of Health is preparing to perpetrate upon the medical profession and the public. I did hope to see my colleagues leading a campaign of protest and public education.

Naturally, Iam referring to the projects that in effect ties the classification of cancer treatment and emergency facilities to the existence of a teaching program in the hospital concerned. The set of rules governing emergency service states among other, more sensible demands that a Comprehensive Emergency Treatment facility must be backed up by operating rooms ready to go within 5 minutes, cardiopulmonary bypass capabilities and in-house 24 hour coverage by specialists who have at least 2 years of training in surgery, medicine and anesthesiology.

It is totally unnecessary to debate the need for the O. R. to be set up and waiting or the bypass capability. It must be obvious to all that both concepts are useless. However, I would like to belabor the demand for what boils down to teaching programming.

The ostensible dividend of this scheme would be lives saved by the shortened reaction time of qualified physicians. Since the only emergency that can not wait a few more minutes is respiratory and cardiac arrest, it can be predicted that no benefit would issue whatsoever. The time that may be allowed to elapse between cardiac arrest and the onset of effective resuscitation is 3 min. in the healthy individual. In the severely ill, acidotic or hypoxic patient this period may well be halved. The battle for life is lost during the time it takes for the LPN to call the RN, for the RN to call the operator and/or the code 99 and so forth. Having participated in innumerable resuscitation efforts in the capacities of both resident and staff, I was always struck by the futility of it all. For invariably it was too late, regardless of how many residents slept in the house or roamed the wards. This is why resuscitation is only successful in the operating room where it is instantaneous, and not elsewhere!

Still, to argue against having a teaching program is almost like arguing against flag, motherhood or intellectual excellence. However, at a time of widespread and highly politicized concern with the cost of medical care it would behoove us all to look at the likely costs of such an undertaking.

The cost is likely to be staggering. The residents salaries, secretarial help, increased numbers of staff for teaching and supervision will have to be provided for. Also, we must add the more hidden cost of inefficiency—surgical procedures dragging at snail's pace, hence more shifts of O. R. personnel etc. To illustrate this let me turn to my specialty—anesthesiology. Taking into consideration the hours worked, numbers of physicians and nurse anesthetists on the payroll and Blue Cross units produced, our department at Wesson Memorial Hospital is more than twice as productive as the teaching hospital I was affiliated with until last fall. It is small wonder then, that the teaching hospitals charge exactly twice as much for each point. Thus, the anesthesia bill for a cholecystectomy presented by our group would be in the vicinity of $70 while the bill from the teaching institution would be about $200.

I do not mean to say anything derogatory about the teaching hospitals. Only, that their role should be to teach, be the pace-setters, discover and disseminate new information. It would be unwise for society to heap more cases on the universities. It would be equally unwise for the community hospital to attempt to become a teaching institute. To the contrary, because we have so many well trained specialists in private practice, as many cases

Letter to the Editor (cont.)

should be done at the private and community hospital level as possible. For at least an economical viewpoint. Should we go the teaching hospital way as prescribed by our Health Dept., we will find that we have priced medical care out of the free enterprise system. The resulting chaos would certainly invite governmental takeover which may be what the proponents of these regulations desire.

Is there anything we can do to improve our present system without substantial cost to anyone? I do believe so! We only have to train the LPN's and RN's on the floors to initiate effective resuscitation. As a result of a rather successful pilot program the ambulances serving a large part of Pittsburgh proper are manned by inner city blacks formerly branded unemployable. At present these men are capable of administering artificial respiration by bag, mask and airway, external cardiac massage, start intravenous infusions, recognize life threatening arrythmias and defibrillate on a physicians orders via communications equipment they are also taught to use. Suburban volunteer firemen receive similar training with rather impressive results. I see no reason why hospital employees with a much better background could not be taught these simple techniques. This way LPN's and RN's could sustain life while the physician in charge is summoned. The results just might render all those excessive demands meaningless and show them up for what they are.

Respectfully submitted;
Peter G. Sellei, M. D.

* * *

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Established in October, 1973, the Oliver Wendell Holmes Endowment will celebrate the centennial of the founding of the Boston Medical Library.

The Boston Medical Library

Founded as a membership corporation in 1875 by Dr. Oliver Wendell Holmes, the original purpose of the Boston Medical Library was to gather invaluable medical information into a central place where it would be easily accessible to all interested parties. At first, the collections were housed in two rented rooms at 5 Hamilton Place in Boston. But, its holdings quickly outgrew those facilities. By the early 1900's, the Library had moved into its own building on The Fenway adjacent to the Massachusetts Medical Society. Here, under the enthusiastic direction of such librarians as James F. Ballard and Charles C. Colby, III, the Library accumulated, through gifts and purchases, a vast array of priceless collections. And, by the early 1960's, the Boston Medical Library could boast of well over half a million books and manuscripts, and literally hundreds of thousands of medical pamphlets and dissertations. However, the space, money and staff did not grow in proportion to these holdings.

Francis A. Countway Library of Medicine

In 1965, the Francis A. Countway Library of Medicine was built to house the combined Harvard Libraries of medicine, public health, and dentistry, along with the magnificent resources of the Boston Medical Library. When this modern and unusual open-stack library opened it became the largest academic library in the nation, second in size to only the National Library of Medicine.

Jointly operated by both medical libraries with a staff of 65, today, the Countway serves fellows of the Boston Medical Library, fellows of the Massachusetts Medical Society, visiting scholars, faculty members, students, and researchers of the Harvard Schools of Dentistry, Medicine, and Public Health, members and professional staffs of the Harvard affiliated teaching hospitals. More than 180,000 persons visited the Countway in 1972-73.

Rare Books and Historical Collections

When the Boston Medical Library and the Harvard Medical Library integrated holdings a department of Rare Books and Historical Collections was created. Currently, these collections extend over the large portion of three floors of the Countway.

Contained within this department are the personal libraries of physicians including that of Dr. Holmes, 800 incunabula (the major number of which came from the collection of the late William Norton Bullard), and all the

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landmark books on medicine from the 15th century to the present. There are large collections of European books from the 15th to 19th centuries; English books from 1475 to 1800, American books from 1688 to 1870; and medical Hebraica and Judaica from the 14th to 19th centuries. The combined holdings of this department total well over 100,000 books and pamphlets, and literally millions of manuscript pieces.

For this reason, the Rare Books and Historical Collections enjoy the prestigious reputation of being one of the largest and most valuable collections of this type in the world. Unfortunately, to date, only little over half of the books have been identified; and the remainder of the collection is completely uncatalogued.

The Oliver Wendell Holmes Endowment

Increased maintenance costs, governmental cutbacks, and a decrease in the value of the dollar have sharply curbed funds available to the Rare Books and Historical Collections. Thus, on June 21, 1973 the trustees of the Boston Medical Library unanimously agreed that an endowment would be the best means of insuring the annual income needed for this department. And, on October 19th, the Endowment was officially announced.

A capital endowment of $3.5 million (plus $350,000 for a fire suppression program) is the goal of this centennial drive. The funds sought will be used for 4 basic needs:

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Within the overall Endowment effort is The Joseph Garland Memorial Fund, established by the Endowment Steering Committee in August, 1973 on receipt of the spontaneous gift of a friend and colleague of the late Dr. Garland. Proceeds from this Fund will endow a position to be called The Joseph Garland Librarian. This librarian will be charged with the overall direction of The Countway's Rare Books and Historical Collections.

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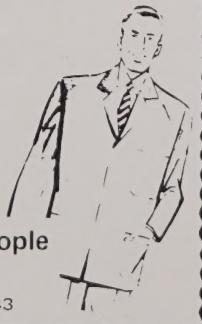

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